STANDARD AUTHORIZATION OF USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION AND PATIENT CONSENT

Information to be used or disclosed

*****The information covered by this authorization includes:**

All medical Information Confirm Appointments Pick up medications Prescriptions

Persons to Whom Information May be disclosed to:

(Please Initial)

_____ ***My primary care provider:*** _____

_____ ***My referring provider:*** _____

_____ ***Name of other person or persons:*** _____

_____ ***No one at this time***

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written request to McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA.

Potential for Re-Disclosure:

The person or organization to which information is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

I understand that as part of the provision of healthcare services, McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that a copy of the Notice of Privacy practices that provides a more complete description of the uses and disclosures of certain health information is posted on the website at McQuaidvein.com. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy, fax or scan of the consent is as valid as the original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that my Protected Health Information which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA is not bound by the restriction unless it is in agreement with the restriction.

Patient's Name (printed): _____

Signature: _____ **Date:** _____

Expiration Date of Authorization: This authorization is effective for 1 year unless revoked or terminated by the patient or the patients personal representative.